1. Last name First name MI

2. Patient Number -- H

3. Date of Birth MM DD YY

4. Race (Check all that apply.) ☐ 1=White ☐ 2=Black ☐ 3=Am. Indian/Alaskan Native ☐ 4=Asian/Pacific Islander ☐ 5=Native Hawaiian/Other Pacific Islander ☐ 6=Unknown

Ethnicity: Hispanic or Latino Origin? ☐ 1=Yes ☐ 2=No ☐ 3=Unknown

5. Sex ☒ 2=Female

6. County of Residence

Medicaid Number

Medicaid Type ☐ 1=Blue ☐ 2=Pink (MPW) ☐ 3=PE only ☐ 4=None

N.C. Department of Health and Human Services
Division of Public Health
Women's and Children's Health Section

MATERNITY CARE COORDINATION PROGRAM INTAKE SCREENING

(See Instructions)

Date of Intake Screening MM DD YY

Verification of Pregnancy ☐ 1=Copy of positive pregnancy test ☐ 2=Copy of current month MPW card ☐ 3=Child's birth/death certificate ☐ 4=Provider verification of pregnancy loss ☐ 5=None available

/ / Date of Last Menstrual Period
MM/DD/YY

/ / Due Date or N/A if postpartum ☐
MM/DD/YY

_ _ Weeks gestation at screening or N/A if postpartum ☐

Pregnancy Intendedness (Check one.) ☐ 1=Wanted to be pregnant sooner ☐ 2=Wanted to be pregnant later ☐ 3=Wants to be pregnant now ☐ 4=Did not want to be pregnant now or at any time in the future ☐ 5=Doesn't know ☐ 6=Declined answering

Family Planning - Using <u>any</u> birth control method when became pregnant. (Check one.) ☐ 1=Yes ☐ 2=No ☐ 3=Doesn't know ☐ 4=Declined answering

Pregnancy History

Number of pregnancies, including this one _ _

Date last pregnancy ended / / or N/A ☐
MM/DD/YY

Prenatal Care

☐ 1=Receiving prenatal care ☐ 2=Not yet in prenatal care ☐ 3=Declined answering

_ _ Number of weeks gestation when prenatal care began *(Leave blank if <u>not</u> yet in prenatal care or declined answering.)*

WIC Status ☐ 1=Referred, but not yet receiving ☐ 2=Receiving ☐ 3=Declined ☐ 4=Ineligible

Maternal Intake Data

_ _ _ lbs. Pre-pregnancy weight

_ feet _ _ inches Height without shoes

_ _._ Pre-pregnancy Body Mass Index (BMI)

BMI = $\frac{\text{Weight in Pounds}}{\text{(Height in inches) x (Height in inches)}}$ x 703

Instructions for the Maternity Care Coordination Program Intake Screening (MCCP-IS)

Purpose: To collect data on Maternity Care Coordination Program client status at the initial MCCP contact.

Preparation: 1. Complete form, entering all required data. 2. Submit data into HSIS. 3. File original form in client's medical record.

Disposition: This form is to be retained in accordance with the records disposition schedule of medical records as issued by the Division of Historical Resources.

Additional forms may be ordered using the Requisition for Maternal Health Materials form (DHHS 3980), available at http://wch.dhhs.state.nc.us/whs.htm.

Last name	First name	MI	Date of Birth / / MM/DD/YY

Psychosocial Risks/Needs Identified at Screening (Check all that apply.)

- ☐ Medicaid Participation
- ☐ Adequate Prenatal Care
- ☐ Medical Home for Self or Family
- ☐ Family Planning
- ☐ Interpreter Services
- ☐ Support System
- ☐ Transportation
- ☐ Employment
- ☐ School Enrollment or GED
- ☐ Child Care
- ☐ Financial Resources
- ☐ Nutritional Counseling
- ☐ Food Assistance
- ☐ Breastfeeding/Infant Feeding
- ☐ Parenting Information
- ☐ Adequate or Safe Housing
- ☐ Smoking Cessation
- ☐ Substance Use
- ☐ Mental Health or Behavioral Health
- ☐ Domestic Violence
- ☐ Sexual Abuse
- ☐ _____
  Local Use/Demonstration

Medical Risks Identified at Screening (Check all that apply.)

- ☐ Previous premature/preterm delivery (<37 weeks)
- ☐ Previous low birthweight baby (5.5 lbs or less)
- ☐ Previous abortion(s) or miscarriage(s)
- ☐ Previous stillbirth
- ☐ Ectopic or molar pregnancy (current or previous)
- ☐ Pregnancy with congenital anomaly (current or previous)
- ☐ Obstetrical problems (current or previous)
- ☐ Multiple pregnancy (current)
- ☐ History of infertility
- ☐ Uterine or cervical abnormalities
- ☐ Vaginal bleeding
- ☐ Recurring UTIs/STIs/Vaginal infections
- ☐ High blood pressure/hypertension
- ☐ Diabetes
- ☐ Gestational diabetes
- ☐ Anemia or sickle cell disease
- ☐ Asthma
- ☐ Heart, kidney, or lung problems
- ☐ Prescription medication

For items below, transfer results from Page 1.

- ☐ Currently age 35 or older
- ☐ Currently age 17 or younger
- ☐ Short interconceptional interval (<6 months)
- ☐ Late entry to prenatal care (after 1st trimester)
- ☐ Pre-pregnant BMI below 19.8 (underweight)
- ☐ Pre-pregnant BMI 26.1-29.0 (overweight)
- ☐ Pre-pregnant BMI above 29.0 (obese)

Maternity Care Coordination Program Information

Enrolled in MCCP? ☐ 1=Yes ☐ 2=Declined ☐ 3=Not Eligible

Name and signature of Maternity Care Coordinator completing form:

Print name: _____

Signature: _____ Date: ___/___/___

Participant Information:

I understand that *I am eligible* to receive Maternity Care Coordination services, and *I wish to participate in the program*.

Print name: _____

Signature: _____ Date: _____/_____/_____

I understand that *I am eligible* to receive Maternity Care Coordination services, but *I do not want* these services.

Print name: _____

Signature: _____ Date: _____/_____/_____

I understand that *I am not eligible* to receive Maternity Care Coordination services, and my appeal rights have been explained.

Print name: _____

Signature: _____ Date: _____/_____/_____